Family Planning and Health Systems Unit

Report on Initial Review of Training Modules on NSV, Mini-lap, IUD Insertion, Itinerant NSV Services

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Background and Rationale

In the LEAD for Health's effort to reduce fertility through increasing CPR, family planning methods will be made more widely available, including quality provision of long-term and permanent methods.

One of the period benchmarks that relates to these aims is:

- Initial review of training modules on NSV, mini-lap, IUD insertion, itinerant NSV services

Constraints to providing IUDs, bilateral tubal ligation (Minilap-LA) and no-scalpel vasectomy include the lack of trained providers, but even more so, is the lack of confidence among providers already trained but with insufficient experience or support to provide and manage the service.

Period Progress

In February, Dr. Douglas Huber from MSH/Boston and JPHIEGO staff Dr. Ricky Lu and Dr. Ron Magarick supported the LEAD for Health team in developing approaches for the project's family planning strategy, including initial consideration of training issues and service approaches. "Procedural" methods (IUDs and VSS) were of key focus.

With the LEAD for Health FPHS Unit, this team met with DOH regional teams in Regions VI and XII and some provincial health personnel. They visited health centers and RHUs to meet with Municipal Health Officers and family planning service providers in Tanza (Cavite); Bacolod, Bago City (Negros Occidental); Talisay (Cebu); and Pantukan and Lupon (Davao Oriental). They also visited district hospitals in Urdaneta and Valladolid in Pangasinan and the Davao Regional Medical Center.

In addition, members of the team visited Friendly Care, met with Dr. Ric Gonzales, Medical Director of The Social Acceptance Project - Family Planning, and other key leaders in health and family planning in both an event to discuss issues in family planning services and the preliminary data presentation of the Demographic and Health Survey. It was also at this time that the findings of the Family Planning Guidelines and Standards review were presented. All readily available curricula related to family planning were made available to the JPHIEGO team.

From these experiences: discussion, site observation, and materials perusal, the team provided an initial review of the strengths and noted areas for improvement in the existing training guides and resource materials for health care workers.

Following their in-country visit, the JHPEIGO team delivered 4 IUD insertion pelvic models, along with training materials and equipment for IUD insertion and removal training, funded by the USAID Training in Reproductive Health Project.

Findings and Considerations

Below are the major findings and recommendations of the team:

1. NSV (including itinerant)

    - The Draft DOH NSV Training Package (December 2002) for groups trained in a static clinic is technically sound.

      Needed: finalization and endorsement by the DOH.

    - NSV in a Rural Health Setting: Training Curriculum and Assessment Tools (MSH/2003) for peer-to-peer training for itinerant NSV service delivery and training is sound with need for additions.

      Needed: more skills transfer structure, complication management, additions to infection prevention section, and quality assurance mechanisms for both training and service provision.

      The need to develop advocacy skills for NSV was clear from the visits with existing providers. When asked why another trained provider in the area is not performing vasectomies, advocacy surfaced as the greatest concern. Training for service managers in advocacy and service design may also need to be added. For example, services can be structured in a variety of ways to meet the needs of men unable to take time off from work.

      The project will need to support LGUs and inter-local health zones in matching preceptors with trained providers, who have not had many cases since they were trained.

2. Minilap-LA (Bilateral Tubal Ligation)

    - DOH Minilap Under Local Anesthesia Training Package is technically sound as a package, but needs to be synchronized.

      Needed: information in the more updated Guidelines document (1999) needs to be reflected in the trainer's and provider's manuals.

      A study of VSS training and the team's field discussions also highlight the issues of providers who have been trained in BTL but have not had the opportunity to become confident with these skills.

Also, interval BTL is a more difficult procedure than when performed post-partum. Because the settings and circumstances for counseling and the procedure are quite different for interval and post-partum BTL, different refresher and new provider training strategies will be needed.

Supplies for clinical materials and local anesthesia drugs need to be secured before "creating" more providers.

3. IUD insertion training

- Currently, IUD training is provided in the 6-week basic/comprehensive family planning course or the 22-day competency-based FP course. The technical content is sound, but could use some minor local adaptations. A stand-alone IUD insertion and removal training package is not available. Providers who have been trained in other methods but are lacking either IUD initial training or are in need of a refresher would benefit from a stand-alone package.

  Needed: Minor adaptations to the Comprehensive and Competency-Based FP training materials.

  A stand alone IUD insertion and removal training package would be useful for the many providers who have basic FP training but are lacking IUD skills, or have been trained but are not yet confident. JHPIEGO has a package that would provide a sound basis for adaptation.

  Refresher training and teaming up with a preceptor to increase confidence in IUD insertion might be initiated with some self-paced materials and models. The project will need to work with LGU and inter-local health zone teams to link a preceptor with providers, who need backup to become confident.

Please see attached technical trip reports for a more detailed discussion of the findings and recommendations of the consultants.

Conclusion

Sound and potentially useful materials exist but can be updated, consolidated, and improved in terms of content. Endorsement by the DOH will be useful for all materials. Trainers have begun to feel confused as they try to sort through the role of each training document, too many of which are referred to as "the green manual". What was not discussed here is the current 12-volume training set for family planning basics and comprehensive. These materials are complete, but how to make the multi-volume set manageable needs to be considered. JHPIEGO has also suggested a review at some stage of the current utility of the basic and comprehensive course in its current 6-week format.

Needed revisions for the NSV, mini-lap, and IUD training and service guides will be undertaken.

ANNEX A

Trip Report: Ricky Lu, MD, MPH and Ronald Magarick, PhD

February 18, 2004

TECHNICAL TRIP REPORT

PROJECT:	Health Enhancing Local Partnerships- Local Government Units (HELP-LGU)
CONTRACT NO:	492-C-00-03-00024-00
CONTRACTOR:	Management Sciences for Health
CONSULTANT:	Ricky Lu, MD, MPH Ronald H. Magarick, Ph.D.
ORGANIZATION:	JHPIEGO
TRIP DATES:	6-18 February, 2004
DESTINATION:	Manila, Philippines
PURPOSE:	To provide analytic leadership and perspectives in developing strategies to improvement contraceptive prevalence and design training and performance improvement interventions for the HELP-LGU Project

ACKNOWLEDGEMENT AND DISCLAIMER

This trip report was made possible through support provided by USAID/Philippines under the terms of contract No. 492-C-00-03-0024-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development or Management Sciences for Health.

Expanding Contraceptive Choice and Method Mix through Strengthening the Delivery of Family Planning Training and Service Delivery in the Philippines: Issues and Recommendations for the LEAD Project

EXECUTIVE SUMMARY

The Local Enhancement and Development for Health (LEAD) project was designed by USAID/Philippines to support its IR 1 and IR 4 under strategic Objective 3 (Desired family size and improved health sustainability achieved).

The project is expected to cover 530 municipalities and cities (Local Governmental Units or LGUs) over a three-year period (2004-2007), covering around 40% of the population of the Philippines, and 80% of the barangays in each LGU. There is also a special emphasis on Mindanao.

Dr. Ronald Magarick and Dr. Ricky Lu of JHPIEGO joined Dr. Douglas Huber of Management Sciences for Health (MSH) in providing analytic leadership and perspectives in developing strategies to improve contraceptive prevalence, and in the design of training and provider performance interventions.

Teams visited a number of rural health units (RHUs) and district hospitals in Cebu, Bago, Davao, Bacolod, Negros Occidental and Tanza. During these visits, discussions were held with service providers, supervisors and administrators regarding both long-term and spacing methods of contraception. The purpose of the visits were to better understand provider performance and the resources to support them, and identify opportunities for LEAD to focus its resources to improve access and quality of FP services.

The team made recommendations in areas relating to the strengthening the performance of midwives, nurses and physicians providing family planning services, including approaches to strengthen the provision of long-term and permanent methods of contraception (NSV, minilaparotomy, injectable contraception). The team also reviewed the numerous existing training materials and recommended how each could be strengthened or revised.

KEY RECOMMENDATIONS:

1. LEAD must work with AED to develop and effectively disseminate family planning clinical standards to each healthcare worker who provides FP services. These standards must be produced in a user-friendly format, like a pocketguide.

2. LEAD's interventions should initially focus on current providers of FP services. While gaps in provider knowledge and skills have been identified, other performance factors such as lack of instruments, supplies and commitment from the LGU will have to be addressed. Performance improvement approaches should be utilized to address gaps in service delivery at LGUs.

3. Establish a Training Information System to track the location of trained providers, clinical trainer and training institutions. The system should also be linked to regional trends in contraceptive use for managers to anticipate training needs.

4. LEAD should utilize GIS approaches to map where interval minilap and NSV services are being provided. This will assist LEAD to identify areas where services and/or training must be started or scaled-up.

5. LEAD must work with other Cooperating Agencies and international donors to address issues of the need to publicize the availability of FP services within the LGUs.

6. LEAD must utilize relevant provider and user behavior data gathered by the Manoff Group to guide its intervention in improving the performance of healthcare workers as well as address clients' needs.

7. The availability of family planning commodities must be closely monitored by LEAD at LGU sites. Should stock outs become commonplace; steps must be taken to address the issue.

8. To help improve access and quality of IUD services within LGUs, selected existing providers (midwives and nurses) should attend a 2-day refresher course focusing on updated clinical practices and its application to strengthen IUD services.

9. LEAD should undertake a variety of activities to strengthen ML/LA services ranging from facilitating a national meeting to identify gaps in ML services provision to strengthening the existing network of minilap trainers

10. LEAD should work to finalize the draft DOH NSV standards, update existing providers in NSV service provision and explore alternative service delivery options for NSV, including providing services during evenings and weekends at new or existing service delivery sites.

11. LEAD should advocate with the DOH for revising the existing DOH comprehensive 6 week FP course. The course should be split into two components update and IUD. Only midwives/nurses interested and committed to providing IUD services, should be enrolled in this course.

12. LEAD should develop a core resource for assisting DOH and LGU strengthen their infection prevention practices. The core resource should include experienced clinical trainers who can assist other clinical trainers, supervisors and providers improve their infection prevention practices. The current IP Guidelines for Healthcare Facilities with Limited Resources and courseware developed by JHPIEGO for preparing providers to apply best IP practices can be used to prepare the core group.

13. LEAD should consider expanding the Preventing and Managing Abortion Complication (PMAC) program. At the minimum, LEAD should access the drawdown account and assist existing PMAC service sites obtain MVA equipment.

14. LEAD must work with LGUs, the DOH other CAs and donors to help establish a sustainable system of training.

15. LEAD should work to develop high quality, evidence-based training materials for distribution to LGUs.

16. LEAD should promote sharing of Best Practices among LGUs. Approximately 12-18 months after the initiation of the LEAD project, a national conference should be conducted to document and disseminate Best Practices in implementing RH/FP interventions in LGUs. International participants should also be invited to share best practices being implemented in neighboring countries. This conference could be coordinated with the World Health Organization's Implementing Best Practices Initiative

I. OVERVIEW

The Local Enhancement and Development for Health (LEAD) project was designed by USAID/Philippines to support its IR 1 and IR 4 under strategic Objective 3 (Desired family size and improved health sustainability achieved).

The project is expected to cover 530 municipalities and cities (Local Governmental Units or LGUs) over a three-year period (2004-2007), covering around 40% of the population of the Philippines, and 80% of the barangays in each LGU. There is also a special emphasis on Mindanao.

Dr. Ronald Magarick and Dr. Ricky Lu of JHPIEGO were asked to join Dr. Douglas Huber of Management Sciences for Health (MSH) in providing analytic leadership and perspectives in developing strategies to improve contraceptive prevalence, and in the design of training and provider performance interventions. The field visits were conducted with key staff from the LEAD project ((Dr. Joe Rodriquez, Dr. Coly Catindig and Joan Littlefield).

Teams visited a number of rural health units (RHUs) and district hospitals in Cebu, Bago, Davao, Bacolod, Negros Occidental and Tanza. During these visits, discussions were held with service providers, supervisors and administrators regarding both long-term and spacing methods of contraception. The purpose of the visits were to better understand provider performance and the resources to support them, and identify opportunities for LEAD to focus its resources to improve access and quality of FP services. Although the sites visited are not representative of the entire health system, all had been providing services for many years and seem to provide a reasonable picture of the gaps in family planning (FP) service delivery and training. Key persons contacted and key sites visited are included in the Appendix.

II. PROVISION OF FAMILY PLANNING SERVICES: ISSUES AND CHALLENGES

Despite a variety of challenges to providing family planning services in the Philippines, the providers with whom we met were generally well motivated and highly supportive of the program. Municipal and Provincial Health Officers in Bago, Bacolod, Tanza, Cavite and Pantukan, Davao Oriental were dynamic leaders. Many dedicated public health nurses who are also family planning coordinators at their RHU impressed the team. The team met a midwife who is a Barangay health worker and a private sector male midwife in Lupon, Davao Oriental who were highly involved in the FP program as well as a dynamic NSV trainer at the Vincente Memorial Hospital in Cebu and an extremely enthusiastic family planning trainer working in Bago City.

Although the team was not able to directly observe actual provision of services, information from interviews and observations indicated that most of the providers have previously received FP training. Many of the providers, though, had not been updated in family planning for many years and their knowledge was out-of-date. On questioning, the team noted that there were serious misconceptions and misunderstandings about the provision of FP methods, including the standard days method (protocol for client use) and IUDs (timing of insertion).

We found that many providers were trained to provide long-term and permanent methods (IUDs, NSV and minilap), but they were not providing services for reasons ranging from lack of commodities, to low client caseload. We found that refresher training is required for the provision of IUD and minilap services.
At sites where providers were trained in NSV, the demand has not been sufficiently adequate to possibly maintain the provider's skill. Demand generation activities have not been actively pursued at these sites. One of the frequent reasons put forward was lack of support from the LGU.

There is demand for tubal ligation services at the facilities that the team visited but few clients get to access these services. At the RHU in Pantukan, clients are referred to a neighboring district hospital because the physician in the district hospital is not supportive of VSS. At Lupon, the lack of a definitive clinic schedule for VSC is a barrier to scheduling cases. In most instances clients are referred to the Davao Regional Hospital (DRH) for services. At the DRH, however, lack of supplies and the preference among providers to use spinal anesthesia for interval minilap remains a major obstacle. Another significant challenge at the DRH is the absence of designated staff who can provide counseling to postpartum and postabortion clients. The Valladolid District Hospital (VDH), which at one time performed 8-10 procedures monthly stopped providing services two years ago primarily due to lack of drugs and supplies, and a surgeon who was not dependable . A newly hired Obstetrician/Gynecologist at the VDH could be trained to provide ML, but the issue of commodities would first need to be addressed. For many months, the Negros Occidental RHU were referring clients to the VDH for ML who all were refused service. Staff at this RHU had not been informed that the VDH was no longer providing services. Clients were then referred to Marie Stopes facilities, which apparently are not as reliable as regularly scheduled services at District Hospitals. At the Vincente Soto Memorial Hospital in Cebu, both interval tubal ligation (TL) is performed, but surgeons are using general anesthesia and very few clients are receiving service (20 procedures in 2003).

As noted, for minilap and NSV, our impression was that to meet present caseload, there generally were an adequate number of providers, but that either their skills needed standardization, (minilap) and/or equipment and supplies were lacking to provide services. To more adequately determine number of new providers that need to be trained for NSV and minilap, LEAD should begin to use GIS approaches to map VSC services to identify underserved locales. In addition, a Training Information Management Systems (such as JHPIEGOs TIMS) is required to help regions to identify the location of current trained service providers and project future training and human resource needs.

While at many of the service sites, the team was told that more nurses and midwives needed to attend the Department of Health's (DOH) comprehensive (6 week) family planning course, it is our impression that LEAD needs to initially focus on updating the knowledge and skills of existing service providers.

The Barangay Healthcare Workers (BHW) have been identified as critical in linking FP services and the community. The MSH Community Based Monitoring Information System (CBMIS) has helped in identifying potential clients. Nonetheless, the PHNs with whom the team met agreed that they would like to see their BHW receive additional training to improve their knowledge in FP methods and communication skills. The midwives who supervise these BHWs and are the main providers of FP in the Barangay have also been identified as needing technical updates and refresher skill training in IUD insertion and removal.

Supervision is an important element of strengthening the provision of services. Responsibility for supervision is fairly clear among the providers at the facilities the team visited. The PHN primarily supervises the midwives who are in the RHU or stationed at the Barangay Health Center. The BHW are in turn the responsibility of the midwives. Much of the supervision that is going on involves quantitative aspect of the program. Although the public health nurse (PHN) claims that they received training in supervision, feedback from our interviews indicated that supervision for improving provider practices in is not the norm. Supervisors also lack current FP knowledge. Additional constraints are the geographic and time issue. Most districts have 1-2 PHNs who have more than 15-20 midwives to supervise.

The provision of high quality services is predicated on compliance to stated standards of clinical practice. Unfortunately, the existing clinical standards for FP are not readily available, are not user friendly, nor do they contain the current WHO medical eligibility criteria for family planning. In Tanza, Cavite, it took the staff about 10 minutes to locate the thick 1997 FP clinical standards binder. In Lupon, the 2 PHNs were not aware that they had a copy of the 1997 standards. The midwife who attended a FP update in 2002 and received Essentials *of Contraception* was able to identify and quickly show the team on what she based her FP clinical practices.

Training is not the only solution to the problems noted. In fact, training is typically only one element in strengthening RH/FP services. Service providers (particularly those at a supervisory level), must be taught to use performance improvement (PI) approaches to identify gaps in service provision at their institutions, and to address these gaps with others within their institutions.

LEAD must also work with other Cooperating Agencies and international donors to address issues of the need to publicize the availability of FP services within the LGUs. It

will do little good to strengthen service provision and training for FP, unless clients and communities are made more aware of the availability of the services.

Literally all of the providers and program managers with whom we met expressed serious concerns about the withdrawal of USAID support for contraceptives in the Philippines, particularly injectable, pills and condoms. While some of the sites indicated that local governments might find approaches to provide the commodities, this was not the general view. LEAD needs to closely monitor commodity supplies at LGUs. Should stock-outs become commonplace, steps must be taken to address the issue. Frontline providers also perceive that the DOH is moving towards natural family planning in anticipation of the loss of funding for the modern methods.
.
Specific impressions and recommendations follow regarding strengthening or expanding long-term and permanent methods, including training materials

III. STRENGTHENING THE PROVISION OF IUD SERVICES

IUDs were available at all of the facilities that were visited. Stock-outs were rare. Most service delivery sites had at least one provider trained to insert IUDs, and at large centers, 3-5 trained providers were available. However these providers need refresher activities, as there are deficiencies in the knowledge area which impact on service delivery. For example, providers mistook the sterility expiry date as indication of the remaining effectiveness of the Copper T 380 A. Providers were also unclear about when to provide IUDs to clients during the postpartum period.
Infection prevention practices are an area, which will also require updating.

Generally, insertion and removal skills do not seem to be a major issue with current providers. However, there are some steps in the procedure that will require additional skill building exercises, for example: bimanual pelvic examination, the application of the tenaculum, no touch technique for loading the IUD in its sterile package.

Instruments for IUD insertion and removal are generally available. However, in high caseload facilities, the number of kits is inadequate. Some of the existing kits being used by the clinics need instruments replaced.

Recommendations:

1. To help improve access and quality of IUD services within LGUs, selected existing providers (midwives and nurses) should attend a 2-day refresher course focusing on “reinvigorating” IUDs in the Philippines. This need-to-know course would review current WHO medical eligibility criteria for IUDs (which expands the client base), counseling essentials for the IUD, review myths and misconceptions about the method, update infection prevention practices associated with the IUD, and would work to build provider confidence by standardizing each providers skills on an anatomical model. A session specifically designed for Barangay midwives will be included to focus on strategies for working with Barangay Health Volunteers to identify and reach out to couples who may need long-term contraception and permanent contraception. If possible, IUD services should be provided by midwives at the BHU.

2. The midwife and nurse supervisor attending the refresher course would be provided an orientation package to enable them to update their staff regarding the new WHO eligibility criteria for IUDs, and other important key elements of IUD service provision. These supervisors will also participate in an add-on supervisory skills building activity to strengthen their mentoring of the midwives they supervise. The performance improvement approach will be used as the context for conducting the technical supervision function.

3. A stand alone IUD Insertion and Removal training document is not available. Current providers usually receive their IUD training integrated into either the DOH 6-week or the more recent 21-day competency based FP course. The technical content of the IUD component of these training courses is generally sound, although updating is required to make them consistent with the WHO Medical Eligibility criteria.

   Expanding the base of current IUD providers and strengthening current providers will require LEAD to develop a stand alone IUD learning resource package. The existing IUD module (module 7) in the competency based FP course can be updated, and used to adapt the JHPIEGO group based IUD training package for use in the Philippines. The adaptation of this training package will take into account the need for new provider and refresher types of training and its application in either a group based or self paced learning environment.

4. To expand the pool of IUD providers in areas that might not have an adequate number of providers, LEAD should consider introducing self-paced IUD training. In this way, the service providers would learn the didactic portion of the training within their own home institution, and would travel to a clinical training site for the clinical practicum. No more than 2 trainees would be at the clinical training site at any one time to allow for clinical exposure. (Note: The project could consider using JHPIEGOs interactive learning approach - ModCal (modified computer assisted learning) to teach the service providers the didactic IUD content. Most sites we visited had access to a computer).

5. Itinerant IUD services should be one of the menu of options that LEAD will offer to LGU's where geographic distance, population density and lack of trained barangay level staff are challenges to expanding access to quality IUD services. LEAD may want to develop an itinerant IUD services starter kit. This will include a package for advocacy, IEC materials, a scenario based step by step "how to" including, LGU without trained IUD providers to LGUs with some RHU based trained providers, and tools for monitoring and evaluating services. The kit will also have templates for job aids and client information materials.

6. IUD equipment and supplies – While IUD kits were available at all the sites visited, as caseloads increase, kits may need to be provided to high-volume sites. LEAD should work with LGUs to make sure that kits are available for on-going services. LEAD should also negotiate with LGUs to include instruments as a line item in their annual budget. This should form part of the equity they bring to the table to participate in LEAD activities.

7. Counseling materials for IUDs – Each site visited had an adequate supply of client materials for IUDs. It would be helpful if LEAD or another partner review

these materials to make sure the information contained is accurate. (We were unable to do this as they were in the local language). It will also be useful for LEAD to develop client instruction materials for new and current users. The format needs to be both for literate and non-literate clients. In counseling, it is always easier for both the providers and the users to have visual aids such as hand held pelvic models or pictures. LEAD can include in its training events discussions on developing visual aids that can be fashioned from local materials.

IV. STRENGTHENING THE PROVISION OF MINILAP SERVICES

Tubal ligation using the minilap under local anesthesia technique is applicable during the immediate postpartum period (up to 7 days) and at interval. Postpartum ligation is typically offered at sites where there are providers who have completed a residency-training program or, have learned the skill during inservice training. Providers who want to perform interval minilaparotomy usually obtain their skills from inservice training or, in rare instances, when they have their preservice education in institutions where this procedure is regularly performed. The 2003 JHPIEGO Assessment of VSS and Training in the Philippines clearly articulates the lack of interval services as well as opportunities for training new providers.

The team repeatedly heard that minilap services were not being provided to standard and that there are periodic stock-outs of anesthesia and other supplies for the procedure. One method-limiting barrier identified during the minilap assessment conducted by JHPIEGO is the lack of Apello retractors to use during the minilap procedure. While other retractors can be used for the procedure, most providers were trained to use this retractor. It would be relatively easy and inexpensive for LEAD to make available these retractors at existing minilap service sites.

We recommend that prior to training new minilap providers, existing providers be updated and service delivery sites strengthened as follows:

1. Regional Meeting of Minilap Providers and Trainers: All currently active minilap provider and trainer teams (physician/nurse) should be invited to a two-day regional meeting. The overall purpose of this meeting is to strengthen the network of minilap providers. The first day and a half will focus on standardization of clinical practices (counseling, infection prevention practices and safe effective pain management) using models. The remaining meeting will be to identify interventions to improve access and quality of care, and opportunities for linkage among providers. A tool kit for improving performance will be introduced in this meeting. Each team will learn how to use the PI approach to improving quality and access. The meeting will also be used to distribute 2 sets of Apello retractors to each provider team.

2. Regional Trainer Supervisory Skill Building Workshop: Trainer Team participants in activity 1 will have an add-on 1-day supervisory skill-building workshop. The purpose of this 1 day workshop is to assist trainers assume the role of mentors during followup field visit. They will also be introduced to the PI approach and how to use the tool kit to be developed for minilap followup visits.

3. Use of the PI approach to address gaps in ML services. LEAD will play a primary role in developing a package of tools and checklists that supervisors at the

regional or provincial level can use during followup visits to minilap service sites. The same set of tools should also be given to providers during the regional meeting so that the role of the supervisors will be to assist and/or facilitate the process rather than lead it. The tool kit will have a "how to" use the PI process at the service delivery site, templates and forms to use for conducting the PI evaluation, and a catalogue of local, regional and national resources who can provide TA.

4. National VSS Coordination Meeting A two-day meeting to be led by the DOH with TA from LEAD should be organized for Regional FP coordinators. The purpose of the meeting is to discuss the VSS program from a SWOT (strengthen, weaknesses, opportunities, threats) perspective. The intended outcome of this meeting will be to agree upon a set of commitments to strengthen current VSS service delivery practices and plans for expanding services.

5. Itinerant Minilap Services: The responsibility for organizing and managing itinerant minilap services will have to be formalized and disseminated widely. This should be at the level of the provincial health office. The regional health office could possibly take the role of coordinating the provider team resources to support the needs of each province. The opportunity for LEAD here will be to provide TA to organize the system and assist in the development of a tool kit for providing itinerant minilap services.

6. Minilap Provider Behavior Change Intervention. Manoff will be conducting some formative research into provider and client attitudes to FP. It will be useful for LEAD to include a panel of questions specifically focusing on Minilap and non-minilap provider attitudes to learn and practice the procedure. The results will be useful in addressing the lack of interest among potential providers.

V. STRENGTHENING THE PROVISION OF NSV SERVICES

There appeared to be an adequate supply of NSV providers, although as indicated earlier, it would be beneficial for LEAD to map location of providers to identify underserved areas.

We found in all of our visits a rather rigid and traditional approach to NSV provision. Services were only provided during the typical workday (8 a.m. to 5 p.m. Monday-Friday). Some sites indicated that clients were provided meals and sites suggested that perhaps they could reimburse the client for lost wages. Alternative service delivery options should be explored by LEAD.

In areas where new NSV providers are needed, LEAD should consider introducing self-paced NSV training. JHPIEGO has successfully introduced this approach in Nepal. In this way, providers learn the didactic portion of the training within their own home institution, and travel to a clinical training site for the clinical practicum. LEAD must make available NSV kits for any new providers trained and ensure that existing sites have adequate equipment.

To increase access and quality of NSV services, the team recommends:

1. Finalization of the draft DOH NSV Standards. The training package for group based NSV training needs to be finalized and endorsed by the DOH. The guidelines in that package will serve as the basic standards for the provision of NSV. The package itself will not require major revisions but it will need a thorough review by an editor and NSV clinical trainer.

2. Develop a site-level implementation Package for NSV. The package is both an advocacy tool and a "how to" set up NSV services. The advocacy piece should target the key stakeholders in the LGUs to support the integration of male participation in RH in both health and non-health programs of the LGU. It will attempt to create political support for establishing a network of NSV sites with the hub located at the RHU. The "how to" component will essentially have options for initiating NSV services ranging from purely external itinerant services and progressing to establishing a network of NSV ready service delivery points. One of the key components of this package will also be a community mobilization strategy based on behavior change data identified by the Manoff Group.

3. Developing Training Options to Improve Quality and Access to NSV Services. Two training options are currently available for provider development in NSV. The group based training approach is trainer and resource intensive to assure quality of training. However, it takes time to organize group-based training and there is no assurance that the new provider will have the confidence to immediately begin providing services without close followup support. The peer-to-peer training methodology, as currently designed, is less resource intensive and in theory will address the issue of immediate application of skills. However, the quality of services provided by peer-trained providers is often open to question. LEAD should strive to strengthen both group-based training and a self-paced training approach linked to practice with an itinerant service. The self-paced learning approach to NSV that JHPIEGO developed for Nepal can be used as the context for conducting a strengthened peer-to-peer training. Briefly, using this approach, the "teaching-peers" will be a team of experienced providers (operator and the assistant) who will be given additional orientation to coach/mentor a new provider. The new provider will use the self-paced learning approach to prepare for the clinical practicum preferably at their own site.

4. Conduct Refresher and Skills Building Training Events. Using the finalized training package, refresher events should be conducted for current NSV providers. It will focus on both technical skills as well as demand generation interventions. Both the NSV provider and their assistants should participate as a team. For experienced provider teams who are interested in mentoring other providers, an add-on mentoring/coaching skills building activity will be offered.

5. Identify and work with Professional Groups who will be the champions for NSV. In Davao, the local association of municipal health officers (MHOs) helps its members who are interested in learning NSV to connect with those who have an on going NSV program. LEAD should explore partnership with such groups to create a network of committed providers.

VI. PHILIPPINES COMPREHENSIVE FAMILY PLANNING COURSE

The Government of the Philippines requires nurses and midwives to attend a 6-week course on family planning to receive certification as a provider. The team reviewed the voluminous course materials and found that much of the material was in need of updating. Further, we view that taking a service provider away from their clinic for approximately 6 weeks is neither cost effective nor efficient.

We believe that this course could be divided into two components (see recommendations in the IUD section also). The first would be approximately a two-week update on family planning for new providers, which would focus on need-to-know information. The text used for this update would be Essentials of Contraceptive Technology available at no cost to the project from the INFO project at Johns Hopkins.

The second component would focus on providing IUD clinical skills to nurses/midwives interested in learning IUD insertion, and where there is a certifiable demand for more providers at the local level. The nurses/midwives would be trained in IUD insertion/removal using the self-paced approach discussed above, or through a group based course of 1-2 weeks (see IUD section also).

We understand that what we are recommending is not current Department of Health policy and that LEAD might have to work with the DOH to effect this change.

VII. PREVENTING AND MANAGING ABORTION COMPLICATIONS (PMAC)

EngenderHealth established several PMAC pilot sites in the Philippines. Some of these sites, such as at the Philippine General Hospital and at Davao Regional Hospital, have continued to offer the service. The team visited one of the sites and noted that the most pressing problem is resupply of the MVA kits. The center started with 7 sets a little over 2 years ago. Presently, there are only 2 functioning sets. Providers are in a quandary regarding how to obtain replacement kits as they are not available through regular medical suppliers.

LEAD should consider expanding the PMAC program to key district hospitals that have very high caseloads of women in need of the service. An essential element of the expansion of the PMAC program would be making certain that each client is counseled about family planning, and receives a method prior to discharge if so requested. In so doing, the number of FP acceptors will also rapidly expand. While LEAD may have other priorities for year 1, expanding PMAC should be considered a high priority in year 2 of the program. However, year 1 must be utilized to support the existing services while at the same time preparing the ground for expansion in year 2. The preparation should include finalizing a training package for PMAC, negotiating for supply of MVA kits and developing draft tool kits for starting PMAC services.

The MVA equipment can be obtained at no cost through the Postabortion Care Consortium drawdown account managed by IPAS, and funded by the Packard Foundation. (Both Pathfinder and JHPIEGO representatives are on the advisory board that provide oversight on the distribution of the equipment).

VIII. STANDARDS DAYS METHOD

There was great interest in the Standard Days Method at literally all of the sites visited. Service provider knowledge about the method was mixed, including some serious misconceptions about how to counsel clients about the method.

One way to rapidly update service providers about the method is to supply the recently developed teaching-tutorial (CD Rom), "Standard Days Method – A Simple Fertility Awareness-based method of family planning" recently produced by JHPIEGO and the Institute for Reproductive Health at Georgetown. Wide dissemination through the LGU supervisors could help reduce many of the myths regarding the method and strengthen the provision of services.

LEAD should help facilitate LGUs to obtain or procure beads. A client brochure on the SDM must also be developed.

IX. SERVICE DELIVERY GUIDELINES

The provision of high quality services is predicated on compliance to stated standards of clinical practice. Existing clinical standards for FP are not readily available in the hands of the users, are not user friendly, nor contain need to know information to safely and effectively provide the services. Additionally, recent updates to use of common contraceptive and also the current WHO medical eligibility criteria for family planning method use are absent. The eligibility criteria are critical to improving a client's choice and access to contraception.

The Social Acceptance Project (TSAP) led by AED is working on revising the FP service delivery guidelines using the latest evidence based clinical practices in FP. AED commissioned a report to critically appraise available FP reference materials in the Philippines (see related item below) and propose concrete recommendations for revision. This report was used as a basis for convincing the DOH to seriously consider revising and updating their guidelines. To date, the process towards completing the update has barely started. While a technical working group has been organized to lead the revision, AED is working on securing the administrative order from DOH to endorse the effort. Its estimate of having a ready to use manual by July may be optimistic given past experience in this area.

There are three things that LEAD needs to focus its attention on this subject. LEAD needs to be actively involve in all aspects of the revisions and development of the service delivery guideline. LEAD also needs to decide what service delivery guideline it will be using in the interim. JHPIEGO is recommending that it use the most recent Essentials of Contraception supplemented by an add-on material on Standard Days Method as the reference document for the training activities that the LEAD program will support. Finally, LEAD needs to close work with TSAP on the contraceptive technology updates they are conducting. Some of the sites where they will be working overlaps with LEAD sites. The groups they will be targeting both at the National and Local level can be used by LEAD to support its effort in improving access and quality.

X. INTRODUCTING THE AUTODISABLE SYRINGE IN SERVICE DELIVERY SITES

LGUs will soon be receiving autodisable syringes for the provision of injectable contraception. As soon as the shipment arrives, it is recommended that service providers be trained in the 3-½ course developed by JHPIEGO, which also includes a broader update on FP methods (focusing on reducing medical barriers). This approach, in part, addresses the issue of the need to update the knowledge of providers.

XI. INFECTION PREVENTION (IP) PRACTICES

Compliance to best practices in Infection Prevention Practices is one of the hallmarks of quality health services. The advent of emerging infections such as Hepatitis B and HIV/AIDS has prompted additional efforts not only to protect clients but also the healthcare workers. Most of the sites that the team visited were generally clean and well maintained. Closer observations of existing practices and interviews with front line provider indicated some areas for improvement. These areas include, basic hand hygiene practices, personal protection, instrument processing and storage, waste management and disposal including sharps handling.

IP practices knowledge and skills of providers were developed during their FP training. The modules in the DOH training document as well as in the 1997 FP clinical standards does not provide sufficient context nor the perspective in the application of best practices in IP. It is also not clear if the clinical trainers who facilitate the IP module are adequately prepared to assist participants with their specific IP needs (beyond what is contained in the training manual) nor are supervisors oriented to integrate IP practices as one of their areas of responsibility.

LEAD efforts should include highlighting infection prevention practices in all aspects of service delivery and integrating these best practices in all FP clinical training.

XII. THE FAMILY PLANNING TRAINING SYSTEM IN THE PHILIPPINES

The following are findings related to specific elements of training and service delivery in the Philippines, with a particular focus on visits made to Tanza, Cavite and Davao Oriental.

During visits, the team was unable to identify what one might call a sustainable RH training system. What we found was somewhat fragmented and typically donor driven.

Illustrative of training issues and needs is the situation in Region IX.

- The Center for Health Development (CHD) in Region XI budget for all training totals about PHP 400,000 for the current year. Although the LGU provide some money for inservice training, the RHO largely depends on donor agencies to supplement the training budget.

- The existing Training Information System cannot monitor or assess the training needs of the region. It is not able to efficiently and regularly update its roster of trained provider (as well as supervisors and trainers), identify their set of knowledge and skills developed during training and nor track dates of

training. The lack of a training information system makes it difficult for the CHD to project inservice training needs as well as anticipate the resources needed to support it.

- Most training that the RHO conducts is new provider training. It usually conducts the 6-week basic and comprehensive FP training for midwives and nurses. The RHO also has used the DOH competency based training (CBT) modules. Generally, the classroom portion of the inservice training is carried out in a hotel where the participants are staying. Pelvic models, instruments and other training equipment are brought to the hotel either from the RHO storage or borrowed from another local NGOs. Clinical practica occurs at selected clinical preceptor sites located in the region. The selections of these sites are based on presence of a trained provider and sufficient caseload and often are in rural health units (RHU). The training coordinator claims that these preceptors are trained to coach or mentor new providers and closely coordinates clinical practice performance with the lead trainers.

- Length of training using the 6-week basic and comprehensive FP schedule was identified as an issue. The size and content of the massive FP CBT training modules is also a concern among the trainers.

- The DOH mandates that trained FP providers undergo periodic refresher training at least every 5 years. The team did not find this happening. With few exceptions, most of the healthcare providers have not attended refresher FP training since their original training in the comprehensive FP course.

- Mechanisms are not in place to evaluate the effectiveness of FP training.

- Although there is guidance as regards accreditation of training institutions, training curricula and the certification of trainers, it is not entirely clear if the RHO follows the guidance.

Recommendation: LEAD must work with LGUs, the DOH other CAs and donors to help establish a sustainable system of training. This will assure that when the LEAD project concludes, a system is in place to carryout the training and materials development interventions initiated by LEAD.

XII. ISSUES IN FP/RH TRAINING AND SERVICE DELIVERY

The Davao Regional Hospital (DRH) staff provides minilap. With the exception of postpartum minilap, physicians prefers to use spinal anesthesia using bupivacaine for pain management. Their rationale includes: ease of operation, the presence of an anesthesiologist, lack of supply of diazepam and meperidine and the context of a teaching and tertiary care hospital. Similarly, in Cebu City, at the Vincente Soto Memorial Hospital we were told that ML was being performed using general anesthesia.

The other issue impacting on VSS services at DRH (and as noted in the recently completed JHPIEGO report on VSC in the Philippines) is the provider preference to use the Apello retractors for minilap. The unit only has 2 retractors for the 7-8 minilap kits

they own.(See ML section).Overall, our impression is that it is important to standardize the procedure among clinical trainers.

One staff member was trained in NSV but has not provided the procedure due to lack of clients and lack of confidence. In many of the other institutions visited, providers indicated to the team that they had either been trained as NSV providers or trainers, yet were not using their skills due to low caseload.

As mentioned previously, there is a network of clinical preceptor sites for FP training at selected RHUs. Although this is an ideal setup for providers from the RHU and Barangay Health Centers to develop their skills in a similar working condition, there are service delivery deficiencies that prevent them from becoming effective role models for high quality FP services. The training coordinator also admitted that they do not regularly evaluate the condition and performance of these practice sites.

An incidental finding, the team also found out that the institution has totally shifted to manual vacuum aspiration (MVA) for uterine emptying and cited the economic benefits of being able to discharge patients from the hospital earlier than if the procedure was performed using the traditional dilatation and curettage. FP is offered to the client and the team has done a considerable number of postabortion IUD insertions and tubal ligations. However, of great concern to the providers, is the lack of replacement MVA equipment. Currently they have only 2 functioning MVA units and the have no information where to order replacements. As noted earlier in this report, LEAD would be able to obtain a supply of MVA kits through the “drawdown” account for provision to sites where providers are trained to provide MVA.

XII. REVIEW OF TRAINING MATERIALS AND CLINICAL STANDARDS FOR FAMILY PLANNING

Overview

The Social Acceptance Project (AED) commissioned a 2003 Assessment Report of the 1997 DOH Family Planning Clinical Standards Manual presents a comprehensive overview of 7 manuals relating to FP/RH training and service delivery being used in the Philippines. (including 1993 and 1997 DOH Family Planning Clinical Standards Manual, Essentials of Contraception, Basic Comprehensive FP Manual, Competency Based Training Manual, Friendly Care Foundation Manual and Module 1) currently used by the various family planning clinics. While their similarities, differences, advantages, limitations and content scope are listed in this report, the following is the Team’s recommendations regarding each document.

The 14 recommendations in the aforementioned report plus the companion Concrete Suggestions for Revising the 1997 DOH Family Planning Clinical Standards fall short of addressing the immediate need of the majority of the end users of this guideline document, the frontline nurses and midwives. The results of the discussions with providers ranging from physicians to midwives articulate this need. At the end of the day, these healthcare providers will want a concise, table-top, user friendly, accessible source of need to know information to be able to help their clients decide, and effectively use the contraceptive method of choice.

The 1999 DOH Competency-Based FP Training Manual

This manual includes (11 Technical/Clinical and 1 Training or Trainers Modules) is a step towards addressing the lengthy 6 weeks Basic Comprehensive FP training. The current design brings it down to 21 working days. The initial 9 days of 8 hour long sessions covers knowledge on FP and classroom development of skills in IUD insertion and removal, and counseling. Participants then graduate to 2 consecutive clinical practice starting with a 5 day long FP clinical practice (except IUD) and followed wither immediately or at a later date, another 7 days of IUD insertion and removal practice at accredited preceptor sites.

The course design and the format of the training document can stand additional refinement. The service delivery components of this material need to be coordinated with any future FP Clinical standards. It also need to strengthen the Infection Prevention Practices, discuss rumors and myths, and the management of complications and side effects. The course design and approach to training, while labeled as competency based, can be streamlined to meet the needs of adult learners. Finally, there is a great need for reformatting the document to make it less bulky, less repetitive and easier to navigate for the trainer to use.

Module 12 is for preparing participants to become trainers in 7 working days. About 2 ½ days are spent on updating and standardizing knowledge while the remaining time is spent on a range of training skills from needs assessment to developing tools for evaluating training. Trainer criteria and participant selection criteria is not spelled out in detail. The essential skills for effective transfer of learning need strengthening. Although there is some focus on classroom interactive activities, the design is weak in terms of coaching and mentoring classroom and clinical practice.

Recommendation: The team believes, as noted in the section reviewing the basic DOH comprehensive FP courses, that this manual be eliminated. If the DOH continues to desire to have this lengthy courses taught, then the material needs a thorough revision and redesign to be made user friendly.

Intrauterine Devices: Increasing Options for Long Term Contraception. A Guide for Local Government Units (Draft/2003), MSH

This is a potentially useful document for newly trained FP providers as well as the FP coordinators at SDP to initiate IUD services. As a “how to” guide to start IUD services the document must focus on the process of developing the political commitment, to integrating the service into the menu of health services offered by the SDP down to a demand generation effort. The clinical and technical information that it currently contains must be edited-out to include only the need to know information on setting up an IUD service (e.g, not on how to load IUDs in the package). Monitoring and evaluation is another component that will be useful in this document.

A stand alone IUD Insertion and Removal training package is not available in the Philippines. Currently, FP providers usually receive their IUD training in

either the 6-week DOH comprehensive course or the more recent 22-day competency-based FP course. The technical content of the IUD training components of these course are close to international standards, although minor local adaptations are required.

Recommendations: The team recommends using the existing JHPIEGO IUD Insertion and Removal Package (with minor adaptations) to teach a stand-alone course.

DOH DRAFT NSV Training Package, December 2002.

This package, which was used by EngenderHealth for training providers, includes a participants and trainer manual, and an illustrated guide for surgeon as a reference manual. This is designed for group-based type of training in a static clinic. A two and three day schedule is offered for refresher and new provider training, respectively. Technical content of the package is sound.

Recommendation: The package needs finalization and endorsement by the DOH.

NSV in a Rural Health Setting: Training Curriculum and Assessment Tools. MSH/2003

MSH developed this document to conduct peer-to-peer training for itinerant NSV service delivery and training. However, the process for effective transfer of knowledge, skills and appropriate provider attitude and behavior needs more structured (e.g., setting up counseling, the role of the assistant, infection prevention practices, etc). Although the technical/clinical content is generally sound, complication management and treatment is an area that need to be added. Infection prevention practices need to be tightened further, for example, the list of supplies requires razor but the checklist emphasizes cutting rather than shaving. Finally, there needs to be a mechanism for ensuring assurance of the quality of training but also the provision of services.

Recommendation: Make revisions as noted above.

DOH Minilap under local Anesthesia Training Package

The package consists of three components: a participant handbook, a trainer's notebook and Guidelines on Minilaparotomy. The first two were from the 1993 version of the minilap-training package (green and white) while the Guidelines (yellow) is an updated and revised version dated in 1999. The technical differences in the two versions of the material do not impact on the safety and effectiveness of the procedure but may be confusing to a new provider.

Recommendation: These materials need to be synchronized so that the changes made in the 1999 ML/LA reference manual are reflected in the participant's and trainer's materials.

Family Planning Updates and Orientation to use of Auto-disable Syringe Participant Handbook and Trainers Notebook, JHPIEGO, (July-Nov 2003)

This package was developed to support an initiative to orient providers on the use of Auto-disable syringes. Additional contraceptive technology updates as well as non-FP topics like maternal and neonatal tetanus elimination and micronutrient deficiency control were added. The content is in powerpoint presentation format. The technical content of the FP part is up to date except for the absence of the standard days method. The material is usually delivered in a 1 1/2 day workshop for providers while trainers spent 3 ½ days to get the updates, review of training presentation skills and do some next step planning.

Recommendation: Drop non-FP topics from the package and emphasize key elements of any newly developed FP standards. The sessions should also be redesigned to provide more opportunities for participants to clarify issues and problems in providing the contraceptive method.

SUMMARY RECOMMENDATIONS

1. LEAD must work with AED to develop and effectively disseminate family planning clinical standards to each healthcare worker who provides FP services. These standards must be produced in a user-friendly format, like a pocketguide.

2. LEAD's interventions should initially focus on current providers of FP services. While gaps in provider knowledge and skills have been identified, other performance factors such as lack of instruments, supplies and commitment from the LGU will have to be addressed. Performance improvement approaches should be utilized to address gaps in service delivery at LGUs

3. Establish a Training Information System to track the location of trained providers, clinical trainer and training institutions. The system should also be linked to regional trends in contraceptive use for managers to anticipate training needs.

4. LEAD should utilize GIS approaches to map where interval minilap and NSV services are being provided. This will assist LEAD to identify areas where services and/or training must be started or scaled-up.

5. LEAD must work with other Cooperating Agencies and international donors to address issues of the need to publicize the availability of FP services within the LGUs.

6. LEAD must utilize relevant provider and user behavior data gathered by the Manoff Group to guide its intervention in improving the performance of healthcare workers as well as address clients' needs.

7. The availability of family planning commodities must be closely monitored by LEAD at LGU sites. Should stock outs become commonplace; steps must be taken to address the issue.

8. To help improve access and quality of IUD services within LGUs, selected existing providers (midwives and nurses) should attend a 2-day refresher course focusing on updated clinical practices and its application to strengthen IUD services.

9. LEAD should undertake a variety of activities to strengthen ML/LA services ranging from facilitating a national meeting to identity gaps in ML services provision to strengthening the existing network of minilap trainers

10. LEAD should work to finalize the draft DOH NSV standards, update existing providers in NSV service provision and explore alternative service delivery options for NSV, including providing services during evenings and weekends at new or existing service delivery sites.

11. LEAD should advocate with the DOH for revising the existing DOH comprehensive 6 week FP course. The course should be split into two components update and IUD. Only midwives/nurses interested and committed to providing IUD services, should be enrolled in this course.

12. LEAD should develop a core resource for assisting DOH and LGU strengthen their infection prevention practices. The core resource should include experienced clinical trainers who can assist other clinical trainers, supervisors and providers improve their infection prevention practices. The current IP Guidelines for Healthcare Facilities with Limited Resources and courseware developed by JHPIEGO for preparing providers to apply best IP practices can be used to prepare the core group.

13. LEAD should consider expanding the Preventing and Managing Abortion Complication (PMAC) program. At the minimum, LEAD should access the drawdown account and assist existing PMAC service sites obtain MVA equipment.

14. LEAD must work with LGUs, the DOH other CAs and donors to help establish a sustainable system of training.

15. LEAD should work to develop high quality, evidence-based training materials for distribution to LGUs.

16. LEAD should promote sharing of Best Practices among LGUs. Approximately 12-18 months after the initiation of the LEAD project, a national conference should be conducted to document and disseminate Best Practices in implementing RH/FP interventions in LGUs. International participants should also be invited to share best practices being implemented in neighboring countries. This conference could be coordinated with the World Health Organization's Implementing Best Practices Initiative

ANNEX A

Scope of Work for Consultancy

1. Ronald H. Magarick, Ph.D.

Management Sciences for Health (MSH) will draw on the technical expertise of its partner organizations, including JHPIEGO, for technical support for the Local Enhancement and Development for Health (LEAD for Health) Project. Dr. Magarick was actively involved LEAD for Health Project startup discussions around family planning with the FP Advisor.

JHPIEGO has worked for 30 years in the area of human capacity development to improve the health of women and children worldwide. JHPIEGO has a long working history in the Philippines. Through the Training in Reproductive Health Project, JHPIEGO collaborated with the Association of Deans of Philippine Colleges of Nursing (ADPCN) to strengthen pre-service nursing education around family planning and reproductive health, and with the Association of Philippine Schools of Midwifery (APSOM) to strengthen midwifery education. Between 1987 and 1994, JHPIEGO initiated activities to strengthen family planning/reproductive health (FP/RH) and enhance trainer/faculty development in five nursing schools and five midwifery schools. By the end of the program in 1998, the number of participating schools had reached 27.

Dr. Ron Magarick has worked for over 30 years reproductive health education and training (20 years with JHPIEGO), and has developed projects in more than 15 counties around the world in Asia, the Near East, Africa, and Latin America. He is a co-author of *Training Skills for Reproductive Health Professionals* published by JHPIEGO and edited three JHPIEGO monographs: *Surgical Equipment and Training for Reproductive Health; Reproductive Health Education and Training: Issues and Future Directions*; and *Reproductive Health in Africa*. As Project Director of JHPIEGO's Training in Reproductive Health (TRH) Project, Dr. Magarick is responsible for overseeing a $90 million cooperative agreement with USAID, working globally to establish integrated pre-service and in-service reproductive health training systems in developing countries in order to increase contraceptive prevalence, improve the performance of health care workers, and reduce maternal and infant mortality rates and the spread of HIV. Dr. Magarick has also served as JHPIEGO's Director for Asia. In Asia, Dr. Magarick developed and guided projects in the Philippines, Egypt, India and Nepal.

As part of the LEAD for Health Project's commitment to meeting unmet family planning services need and to meeting the Project's goals, the Project will undertake a focused effort in February to review proposed FP activities and refine strategies in light of dynamics affecting services utilization and service delivery along with identifying feasible, effective interventions. Dr. Doug Huber, Principle Medical Officer for reproductive health at MSH, Boston will lead this process of reviewing information available and bringing to bear local and international expert opinion.

JHPIEGO, as the Project's key partner in family planning and reproductive health service development, will play a key role in the implementation of the refined FP strategy and it's interventions. To that end, it is important that JHPIEGO technical leadership be integral to the strategy process. Dr. Magarick will support Dr. Huber in providing analytic leadership and lend his particular strength in developing strategies to improve CPR and

in designing training and provider development interventions. He brings with him JHPIEGO's global, regional, and Philippines experience in strengthening both public and private sector capacity and quality of care to task of further designing project interventions.

Specifically, Dr. Magarick will:

1. Review the proposed family planning strategies in the first annual work plan using relevant information from the 1998 DHS, subsequent annual FP surveys, current studies, and local and international expert opinion.
2. Support refining the strategies to improve effectiveness and raise prevalence of modern methods, especially counseling, injectables, IUDs, and voluntary sterilization.
3. Identify possible strategic approaches to training and provider development leading to enhanced access to all services and methods, with particular focus on IUDs (post-partum and on demand), injectable contraceptives, and voluntary sterilization: NSV and minilaparotomy.
4. Provide initial assessment of the complement of training available, including the quality of training guidelines.
5. Provide recommendations to address deficiencies and constraints identified in the Voluntary Surgical Sterilization review carried out by JHPIEGO.
6. Deliver a trip report summarizing his work and recommendations to the LEAD for Health project, and next steps. The trip report will follow the provided format and will be delivered to the Project in electronic format prior to departure.

Dr. Magarick will work under the technical supervision of Dr. Jose R. Rodriguez, Director of the Family Planning and Health Systems Unit (FPHSU) and Ms. Joan Littlefield, Family Planning Advisor, with specific input from Mr. William R. Goldman, Chief of Party and other members of the LEAD for Health team.

Period of Performance: on or about February 8-18, 2004

2. Ricky Lu, MD, MPH

Management Sciences for Health (MSH) will draw on the technical expertise of its partner organizations, including JHPIEGO, for technical support for the Local Enhancement and Development for Health (LEAD for Health) Project. Dr. Ricky Lu has technical and regional experience especially relevant to the project's needs.

JHPIEGO has worked for 30 years in the area of human capacity development to improve the health of women and children worldwide. JHPIEGO has a long working history in the Philippines. Through the Training in Reproductive Health Project, JHPIEGO collaborated with the Association of Deans of Philippine Colleges of Nursing (ADPCN) to strengthen pre-service nursing education, and with the Association of Philippine Schools of Midwifery (APSOM) to strengthen midwifery education. Between 1987 and 1994, JHPIEGO initiated activities to strengthen family planning/reproductive health (FP/RH) and enhance trainer/faculty development in five nursing schools and five midwifery schools. By the end of the program in 1998, the number of participating schools had reached 27.

Dr. Ricky Lu, an Obstetrician/Gynecologist, has been an active FP/MCH service provider and Master Trainer for over 14 years working in countries such as the Philippines, India, Nepal and Indonesia. He has been instrumental in the development of national reproductive health training systems in more than a dozen countries. Currently, Dr. Lu's work is focused on promoting the quality of the technical program interventions in the areas of: strengthening the safety and effectiveness of Voluntary Surgical Contraception clinical services; developing a sustainable district-based training network; and in establishing Postabortion Care training and service units. Dr. Lu brings strong credentials to building training and performance improvement systems, counseling and providing clinical FP and STD services, developing and standardizing training curricula and service delivery guidelines and evaluating trainee performance. Dr. Lu is also a skilled surgeon and has served as a clinical trainer with proficiency in obstetric surgery, gynecological procedures including laparoscopy, and minilaparotomy under local anesthesia. He is experienced in the use of innovative training methodologies and in the development, implementation and evaluation of new educational and training models.

As part of the LEAD for Health Project's commitment to meeting unmet family planning services need and to meeting the Project's goals, the Project will undertake a focused effort in February to review proposed FP activities and refine strategies in light of dynamics affecting services utilization and service delivery along with identifying feasible, effective interventions. Dr. Doug Huber, Principle Medical Officer for reproductive health at MSH, Boston will lead this process of reviewing information available and bringing to bear local and international expert opinion.

JHPIEGO, as the Project's key partner in family planning and reproductive health service development, will play a key role in the implementation of the refined FP strategy and it's interventions. To that end, it is important that JHPIEGO technical leadership be integral to the strategy process. Dr. Lu will support Dr. through lending his strengths in the design and improvement of various FP services along with his expertise in innovative training design for performance improvement. In particular, his direct expertise in providing and training in voluntary surgical sterilization will be support strategies to increase accessibility. Dr. Lu also brings with him JHPIEGO's global, regional, and Philippines experience in strengthening both public and private sector capacity and quality of care, in particular lessons from recent successes in the Indonesia program. Specifically, Dr. Lu will:

1. Review the proposed family planning strategies in the first annual work plan using relevant information from the 1998 DHS, subsequent annual FP surveys, current studies, and local and international expert opinion.
2. Support refining the strategies to improve effectiveness and raise prevalence of modern methods, especially injectables, IUDs, and voluntary sterilization.
3. Identify possible strategic approaches to training and provider development leading to enhanced access to all services and methods, with particular focus on counseling, IUDs (post-partum and on demand), injectable contraceptives, and voluntary sterilization: NSV and minilaparotomy.
4. Provide initial assessment of the complement of training available, including the quality of training guidelines.
6. Provide recommendations to address deficiencies and constraints identified in the Voluntary Surgical Sterilization review carried out by JHPIEGO.

7. Provide initial recommendations for clinical guidelines that guide making voluntary surgical sterilization safely available in less restrictive settings.
8. Deliver a trip report summarizing his work and recommendations to the LEAD for Health project, and next steps. The trip report will follow the provided format and will be delivered to the Project in electronic format prior to departure.

Dr. Lu will work under the technical supervision of Dr. Jose R. Rodriguez, Director of the Family Planning and Health Systems Unit (FPHSU) and Ms. Joan Littlefield, Family Planning Advisor, with specific input from Mr. William R. Goldman, Chief of Party and other members of the LEAD for Health team.

Period of Performance: on or about February 8-20, 2004

ANNEX B

KEY CONTACTS

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ANNEX B

Trip Report: Dr. Douglas Huber

February 20, 2004
(With minor revisions 6 March 2004)

TECHNICAL TRIP REPORT

PROJECT: Local Enhancement and Development for Health (LEAD Health)

CONTRACT NO: 492-C-00-03-00024-00

CONTRACTOR: Management Sciences for Health (MSH)

CONSULTANT: Douglas Huber

ORGANIZATION: Center for Health Services and Systems, MSH

TRIP DATES: 30 January to 20 February 2004

DESTINATION: Manila, Philippines

PURPOSE: Review the proposed family planning (FP) strategies for the first year work plan in relation to Demographic and Health Surveys (DHS), international FP standards, applying local and international expert opinion. Consider the method-specific opportunities and challenges in relation to the goals and objectives of the LEAD Project, particularly increasing the modern method contraceptive prevalence rate (CPR). Collaborate with Drs. Ron Magarick and Ricky Lu of JHPIEGO to address technical strategy and training.

ACKNOWLEDGMENT AND DISCLAIMER

This trip report was made possible through support provided by USAID/Philippines under the terms of Contract No. 492-C-00-03-00024-00. The opinions expressed herein are those of the author and do not necessarily reflect the views of the U.S. Agency for International Development or Management Sciences for Health.

EXECUTIVE SUMMARY

To accomplish the purpose of this visit, we made a number of clinical site visits, met with other CAs, social marketing groups, LEAD staff and LEAD partners, and held a workshop with major FP stakeholders. This provided a rich basis for addressing issues to achieve the LEAD Project goal to increase the modern method CPR at a time when donated contraceptives are being phased out. My visit overlapped with that of Ricky Lu and Ron Magarick of JHPIEGO, and with Laurie Krieger of The Manoff Group, Inc. We conducted several joint site visits, which gave us a better understanding of these partners on LEAD.

My thoughts and suggestions here are preliminary, based on a short visit and the information available. I expect these will evolve as more information is known and as my colleagues modify and refine these points.

The new DHS findings from the 2003 survey showed a slight decline in fertility since 1998 and modest changes in contraceptive use patterns. OC use increased from 9.9% of currently married women of reproductive age (CMWRA) in 1998 to 13.2 % in 2003. Being the leading method of contraception, OCs probably offer the most potential for increased CPR in the next 2-3 years. This could be assessed in some strong LGU programs making generous supplies of OCs available (as well as other selected modern methods), anticipating increased use.

IUDs and injectables (DMPA) have both increased slightly, and each offers potential for increased CPR. In Asia, DMPA has frequently been a method that achieves high use rates in a setting of adequate supplies, good counseling and management of menstrual changes. Increasing IUD use will require refreshing the skills of midwives, which is a reasonable focus for LEAD and other agencies working with midwives.

OCs, DMPA, IUDs, and possibly the standard days method (SDM), are the most likely candidates to serve the short-term needs for the 20% of couples who are not using FP but want no more children or want to delay the next pregnancy. Calendar rhythm and withdrawal are widely used, 6.7 and 8.2% respectively, and offer potential for shifting to SDM or other modern methods. SDM is new and its current use is very low.

Female voluntary surgical sterilization (VSS) is the second leading method, and will be popular, especially given the large number of couples who want no more children. Increasing VSS services may rest on the ability to compensate for costs (through insurance or other means), as well as to improve training and management of VSS services. Postpartum (PP) VSS appears to be the most common timing for female VSS, being convenient for the woman, technically easy and cost-efficient for medical facilities. The immediate PP approach (usually within 24-48 hours after delivery) is acceptable and can be expanded, as long as informed choice, good counseling and quality of care are maintained.

Condoms appear to be little used for family planning, 1.9%. Male VSS, LAM and Mucus/Billings/Ovulation methods are very low, 0.1%, 0.3% and 0.1% respectively. These are unlikely to contribute to increased CPR during the project. However no-scalpel vasectomy (NSV) increased in selected settings in the last project. It may deserve continued effort where it was begun, and requires more effort to be sustainable.

Increasing access to OCs and DMPA through collaboration with the private sector--social marketing and commercial firms--is an attractive option at present, considering the need to address a large commodities gap. This sector may also present opportunities for improved contraceptive education for clients and providers to reduce dropouts. These sectors have the potential for wide coverage of information and product, which will be needed for the project. At present the social marketing sector is selling about 8 million cycles of OCs per year.

Continued technical collaboration among the LEAD partners, with other CAs and experts in the Philippines will be needed to make best use of new technical information, provider training and innovative public/private collaboration to increase CPR. MSH Boston RH staff are available and enthusiastic to support LEAD with TA to develop expanded modes of quality services for the newer and the standard modern methods.

KEY FINDINGS AND RECOMMENDATIONS

FINDINGS—Organized by Project End Goals:

PROJECT END GOAL—Increased access to quality modern contraceptive supplies and services

- A major strength of the program is the midwives. They are key providers of modern methods—OCs, injectables and IUDs. BHWs are a major source of OC resupply. Midwives can be more effective providers of IUDs by updating their skills and building confidence. Nurses are fewer in number and frequently leave the country for overseas employment.
- Fifteen million cycles of OCs per year from USAID are being phased out. LEAD will need to facilitate the replacement of about 40%, or 6 million cycles per year, in the target LGUs. Another 1-2 million cycles will be needed to increase CPR. The sites we visited were receiving reduced or no supplies from DOH for OCs, injectables and condoms. One explanation was that the DOH had difficulty procuring OCs (and DMPA?) in the last quarter of 2003. Municipal Health Officers (MHOs) and DOH regional staff are very concerned about the lack of supplies and current absence of alternative procurement.
- Postpartum (PP) female VSS (usually within 48 hours of delivery—up to one week) is available and readily provided at some district and regional hospitals. Services can be increased with small inputs, such as additional counseling and a means of paying for supplies. Health insurance reimbursement (Ps 3060) makes PP VSS attractive for public hospitals.
- PP IUDs, inserted at 4-6 weeks after delivery, could become more common with emphasis on FP as a part of safe motherhood and with updated skills training for midwives. PP VSS (usually within 24-48 hours) and IUDs (at 4-6 weeks) need to be considered as an element of good maternity care. WHO guidance will give confidence in the safety of the Copper T 380A. Injectables can also be provided at 6 weeks PP for breastfeeding women. LAM is not widely used and may not be very effective for most Filipino women, 2/3 of who do not fully breastfeed for 6 months. LAM (or simply breastfeeding) with a progestin-only pill (POP) or DMPA will be highly effective.
- Interval female VSS and IUD insertions (later than 6 weeks PP), are being arranged through itinerant services in some sites. This is a reasonable

approach, when timing is more flexible and where facilities are adequate, e.g., a district hospital for female VSS, or RHC or BHS for IUDs. This approach also presents opportunities for clinical skills training, where a number of procedures are needed to achieve competency—female VSS, NSV, and IUDs.

- SDM was enthusiastically endorsed in some sites we visited. I reviewed the results of pilot introductions in Friendly Care, Jose Fabella Hospital, Kaanib (an NGO), Ipil, Benguit Province, and Malaybalay. The number of acceptors was generally small, with typical effectiveness usually equal to or better than that of the condom. SDM was practiced in conjunction with condoms or withdrawal during the fertile days for 30-40% of couples at Friendly Care and Jose Fabella, with the proportion of combined users increasing over time. IRH has distributed about 42,000 sets of Cyclebeads with client cards, although data is not available on the number of users. Favorable statements have come from individual Catholic bishops, the Catholic Bishops' Conference of the Philippines (CBCP), and the Dept of the Interior and Local Government—but not yet from the DOH. At some sites we visited, SDM beads and training materials were difficult to obtain due to cost or no money allocated for purchasing.
- Social marketing of OCs is quite successful (DKT sells about 8 million cycles per year). DKT and possibly other private providers might be able to fill much of the impending OC gap, particularly if LGUs will purchase low-priced commodities and distribute free to the poorest clients.

PROJECT END GOAL: <u>Reduced rate of dropouts among pill and DMPA users</u>

- Regular supplies must be available to reduce dropout, especially for OCs and DMPA. Good counseling, follow-up, and management of side effects is essential for success, particularly with DMPA (previous experience in the Philippines documents both high and low continuation, depending on the service delivery approach).
- The DKT package brochure for DMPA (Depotrust) is much better than the insert for higher priced Depo-Provera (the other brand of DMPA). LEAD's collaboration with DKT and/or other private sector suppliers might provide wide coverage for improved understanding and management of important common side effects such as menstrual changes and amenorrhea. Good counseling by providers will be the key to reducing dropouts, especially for DMPA. A steady supply will be even more crucial to sustaining and increasing injectable use, given the shortages of DMPA currently reported at health centers and by other CAs (e.g. JSI Deliver).
- Written materials are not currently provided to clients—OCs, DMPA, IUDs, or VSS. Simple inexpensive written instructions and information to complement verbal information can improve use and client satisfaction for their chosen method. These materials will also help address incorrect beliefs about methods. AED is starting an effort to address the main misconceptions, through evidence based materials. AED staff are eager to collaborate with LEAD.
- The value of informing clients became clear in an interview with a woman who had increased menstrual bleeding and cramping after her IUD insertion.

She did not consider either a problem because she had been told to expect these changes.

PROJECT END GOAL: Missed opportunities reduced

- The antenatal and postnatal periods are times when FP information and PP services can be provided with low cost and high acceptance. Other health encounters, such as childhood immunization services, can also be opportunities.
- Professional associations--OB/GYNs, nurses and midwives--could endorse FP as a part of safe motherhood, which would fit with their own efforts to provide FP service delivery.
- Enrolling clients in insurance systems and helping LGUs and hospitals to access reimbursement will help increase FP clinical services, based on our observations.
- Post-abortion care should provide FP services on site to all women with incomplete or septic abortions who do not want another pregnancy soon. Post-abortion FP should be available to women with traditional D&C procedures as well as manual vacuum aspiration (MVA). (See appendix for good hospital statistics on post-abortion contraception at Urdaneta District Hospital, Pangasinan).
- Providers are eager to introduce SDM to couples currently using calendar rhythm or withdrawal. The proportion that may shift to SDM is unknown. There are a large number of calendar rhythm and withdrawal users who would be potential candidates for SDM. SDM, being a "modern method" will count toward the LEAD goal of increasing CPR, and should improve effectiveness. There may be opportunities to collaborate with local cottage industries to make beads. MSH staff already have experience in introducing SDM, and JHPIEGO has a training CD which may be useful. The IRH materials from the Philippines appear to be user friendly, and could probably be copied with permission.
- As one of the few methods for men, NSV should to be supported in the project. There is also interest and capability among LEAD staff for providing NSV. However the numbers of vasectomy are small compared with female VSS. Currently there are over 100 times more women than men using VSS. Vasectomy is an important service, though it cannot be expected to contribute large numbers to the CPR in the short term. It can be a good investment of time and effort that will be important over the longer term.

PROJECT END GOAL: Functional Health Information System

Measuring performance and progress in the service delivery context is important and needs a focus on those measures key to documenting project success:

- Reporting the simple rate (percent) of post-abortion women leaving the facility with a method of family planning can be a good institutional mechanism (as at Urdaneta) to monitor success with post-abortion FP. This is a statistic which often shows major changes in a short time period—from zero to 30-60% in a few months. JHPIEGO has experience introducing post-abortion care, including contraception (called preventing and managing abortion complications—PMAC, in the Philippines).

- LEAD needs to quickly show some progress toward increasing CPR. Measuring CPR at the community level will be important, either as an extension of the CBMIS, or with sample surveys, especially in pilot sites. Measuring CPR at the local level, through household mapping or other means is an excellent way to encourage BHWs and midwives to work toward increased FP use in the entire community, irrespective of source. CPR is a function of both new acceptors and continuation, thereby serving as a more practical surrogate for drop out rates (which can be difficult to measure outside of high-cost research settings).
- Measures of FP performance will probably be unfavorable or stagnant in some LGUs during the transition from donated commodities. Therefore, accurately documenting success in those LGUs making special efforts to meet FP needs could be very helpful in stimulating others and giving guidance to the Project. Innovations to rapidly expand OCs, injectables and perhaps SDM, will be most feasible. Long-term clinical methods will contribute to the CPR more gradually, with the expectation that method switching will occur for couples who want no more children (but cannot get VSS or and IUD until clinical services are strengthened).

RECOMMENDATIONS

1. Place emphasis on OCs and DMPA for meeting unmet need in the short term. IUDs training and services can be expanded at the same time, and potentially serving the considerable number of women who want no more children. SDM is new and may be a good modern option for couples using calendar rhythm and withdrawal. An intensive small pilot effort by LEAD may be informative, as the actual potential for SDM is not known.
2. Strengthen PP services for female VSS (within 24-48 hours) and IUDs (at 4-6 weeks PP) for these two highly effective long-term methods. Midwives can be a good source for providing IUDs and referral to PP VSS services. Midwives doing a safe deliveries can refer women to a nearby hospital willing to perform PP VSS (this model worked well in Thailand).
3. Support interval female VSS, (minilaparotomy) and IUD services to ensure options and expand services and skills. Itinerant teams--doctors performing interval minilap and midwives inserting IUDs—is acceptable and efficient for providers and clients. Ensure that the guidelines for informed choice and quality are carefully followed, especially in itinerant service settings.
4. Continue exploring ways to engage social marketing distributors to improve options for LGUs to obtain OCs and injectables. Engage with other commercial providers as well, to maximize coverage and options. Options will be good for LEAD, the LGUs and the client beneficiaries.
5. Participate in the working groups developing new national FP guidelines. Invite RH Boston staff to contribute new evidence-based technical information for the guidelines and training material.
6. Develop client instructions and job aids for providers with partner organizations or other CAs. Aim to keep these simple and inexpensive in order that they can be widely disseminated soon and maintained after the project.
7. Collect accurate CPR data in selected LGUs--those expected to give high performance, in order to learn quickly what may work the best in the current context.

8. Support clinical settings providing prevention and management of abortion complications (PMAC), and enable them to provide post-abortion contraception to women having MVA and D&C procedures. Collect data on the percent of post-abortion patients who leave the facility with a FP method. JHPIEGO and MSH/Boston should be able to provide technical support and training on this element.
9. Consider providing extra DMPA in the contraceptive mix for ARMM, as underserved populations in Asia, including Muslim, have accepted DMPA at relatively high levels. Current use patterns in ARMM give some support to this suggestion.
10. Use "Essentials of Contraceptive Technology" for field handbook to update providers while awaiting new FP guidelines to be drafted by AED and DOH. Selected practices and new medical eligibility criteria (MEC) from WHO can be included in separate handouts (e.g., newer information on neutral effect of copper IUDs on pelvic infection), and in updating training curricula. MSH/Boston and JHPIEGO can assist with this content.

PARALLEL CONSULTANCIES

The following parallel consultancies occurred during the course of my visit:

1. Charlie Stover, MSH/Boston gave overview of project development and the context of working with other organization, such as DKT, JHPIEGO, and Manoff.
2. Dr. Ricky Lu, JHPIEGO and I visited clinical sites, hospitals, and rural health centers to assess the quality of services and to consider training needs to support LEAD objectives. We also met with other trainers and collaborating organizations, including AED and JSI.
3. Dr. Ronald Magarick, JHPIEGO, along with Dr. Lu considered approaches for training and improved quality of care, particularly for the clinical methods of family planning.

ANNEX A

Scope of Work
For consultancy by Dr. Douglas Huber
On or about February 1-21, 2004

MSH expects to draw on the extensive worldwide experience of its Center for Health Systems Strengthening (CHSS) for wide range of technical support for the LEAD for Health Project. CHSS staff participated in preparing sections of the LEAD for Health proposal, and in certain tasks during initial startup and work planning.

Dr. Douglas Huber serves as MSH's Principal Medical Officer for reproductive health and HIV/AIDS. He is a leading expert on contraceptive technology. Since joining MSH in 2000, Dr. Huber has worked at MSH on a wide range of projects in family planning and contraceptive technology. In mid- 2003, Dr. Huber led the successful review of the quality of the non-surgical vasectomy (NSV) services supported by MSH's PMTAT Project, funded by USAID/Philippines. Prior to joining MSH in 2000, Dr. Huber served as medical director of Pathfinder International, and as medical director for the Association for Voluntary Surgical Contraception (AVSC) - now Engender Health. During his 30-year career, Dr. Huber has worked in over 35 countries. He was co-chair of the Technical Guidance and Competence Committee of USAID's Maximizing Access and Quality initiative. He served on the October 2003 WHO Expert Technical Consultation on the Medical Eligibility Criteria for Contraception, and he is currently revising the international contraceptive handbook, *Essentials of Contraceptive Technology* as a member of the core writing team.

During his proposed trip, on or about February 1-21, 2004, Dr. Huber will participate in the preparation of detailed family planning strategies and provide updates in contraceptive technology. Working with members of the LEAD team, USAID CAs working in family planning, and partner and collaborating agencies and organizations, he will help assess, refine and further specify the family planning strategies by method mix that are included or implied in the first annual work plan of the LEAD for Health Project.

Dr. Huber will provide ongoing inputs to the LEAD project on the latest developments in contraceptive technology, quality methods, and strategies to increase modern method CPR through high quality, accessible services.

During this consultancy, Dr. Huber will:

1. Review the proposed family planning strategies in the first annual work plan using relevant information from the 1998 DHS, subsequent annual FP surveys, current studies, and local and international expert opinion.
2. Help refine strategies to improve effectiveness and raise prevalence of modern methods, especially injectables, IUDs, and female sterilization.
3. Identify ways to move women from calendar rhythm and withdrawal to the Standard Days Method (SDM) or to modern methods to help reduce failures and avert abortions.
4. Assess the current use of injectable contraceptives, program and training guidelines, and the current climate regarding injectables. Review the previous

experiences (both successes and failures) with injectables in the Philippines and other Asian countries.

5. Consider ways to get NSV more widely accepted to make long-term difference in prevalence, (the ratio of female to male sterilization being >100:1 overall).
6. Assess strategies to assure a balanced effort with female and male sterilization building on success with NSV, recognizing that larger numbers will be more feasible for female sterilization.
7. Assess how immediate postpartum (PP) services can add acceptance and prevalence, since PP mini-laps for female sterilization is easy to delivery, and the Philippines is well endowed with skilled and experienced providers in PP sterilization.
8. Review experiences to introduce PP IUDs successfully in some settings, and assess its potential as a major way to delivery IUDs in the Philippines.
9. In light of the new guidance from the WHO expert committee on medical eligibility criteria that is giving a greener light to IUDs (less concern about infection); explore ways to expand use of this method.
10. Deliver a trip report summarizing his work and recommendations.

Dr. Huber will work under the technical supervision of Dr. Joe Rodriguez, Director of the Family Planning and Health Systems Unit, and Ms. Joan Littlefield, Family Planning Advisor, with specific input from Mr. William Goldman, Chief of Party, and other members of the LEAD team.

ANNEX B

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ANNEX C

SUPPORTING DATA

Postpartum female voluntary sterilization, postabortion contraception and postabortion care, including MVA

1. **Don Amadeo J Perez Sr, Memorial General Hospital, Urdaneta City, Pangasinan: Report of Female VSS by Postpartum and Interval Status (only hard copy available)**

This district hospital is a training site for minilaparotomy and has a good service for PP VSS. The procedures are done in the immediate and early postpartum period (up to one week), and in the later postpartum period as well (8-28 days PP). The service is active and represents a good model for service delivery. It would be good for LEAD to identify the total number of vaginal deliveries by month (data routinely available in most hospitals), in order to calculate the PP VSS rate as a percent of women having vaginal deliveries who receive a PP VSS procedure.

Based on my observations over the years, I developed a simple scale by which to assess performance for PP VSS. The level of performance is expressed as a **percent of women who receive a PP female sterilization procedure before leaving the facility among all women having vaginal deliveries.** (numerator is number of PP VSS in a given period and the denominator is all women having vaginal deliveries in the same time period)

Postpartum female sterilization performance index (D Huber):

1. **Highly active service 15-20%** (The upper limits of PP VSS in any part of the world has been about 25%--higher than 25% is probably inappropriate).
2. **Active service: 10-14%**
3. **Modest service 5-9%**
4. **Relatively inactive service 3-4%**
5. **Inactive service 1-2%** (At this level one may assume that VSS is only provided for women who have a compelling health/medical reason whereby another pregnancy will be a serious risk to her health or life. VSS for routine contraceptive purposes is generally not provided).

I commend applying this measure for monitoring VSS performance in maternity settings with surgical capacity, and I suggest that colleagues in these institutions use it to assess their own performance.

In the past (and perhaps at present), Jose Fabella Hospital had a **highly active service** with about 15% of women receiving PP VSS after vaginal delivery. They used a refined minilap technique that does **not** extend the normal postpartum stay in the hospital. The service should avoid extending the normal hospital stay to be cost-effective. No prolongation of stay can be an indirect measure of quality, as well, as it implies local anesthesia with a small incision and light (or no) sedation.

This measure is restricted to VSS after vaginal deliveries, since female sterilization at the time of Cesarean section requires no additional support, is simple and quick to do as part of the operative procedure and is often done for medical reasons (risks associated with a high number of C sections), rather than as a contraceptive service.

Interval female VSS (after 4-6 weeks postpartum) is less performed at this district hospital, which is understandable, given the extra difficulty for women and providers to organize and deliver this service. Having an abundance of PP VSS, in comparison to interval ML, is a typical in many hospital settings.

The surgical team organizes itinerant female VSS at other hospitals with surgical capacity. The Urdaneta staff take equipment and supplies. Local staff provide counseling, and organize women and facilities to perform VSS for 20-40 women in the course of 2 days. Follow-up is then provided locally, including the management of any surgical complications.

This itinerant approach can be a good complement to PP VSS. Interval procedures can be organized for a larger number to be done at one time, well trained surgeons can teach other staff, including those at the host facility, and the service can meet the needs of a substantial number of couples. Transport and local involvement in pre-operative counseling and post-operative care are managed close to the woman's location and is therefore conducive to high quality services.

Some special guidance and ground rules for itinerant services are generally needed to ensure: 1) good counseling and appropriate screening, 2) sufficient equipment, 3) infection prevention, 4) preparation of facilities, 5) number of cases performed (not to exceed the duration of operating time and number that can be safely performed by individual surgeons), and 6) adequate follow-up care by local staff to manage complications.

Post abortion care (PAC) with uterine evacuation was provided to 298 women in 2002. Immediate PA contraception was provided to 122 women, an overall immediate postabortion contraceptive use rate of 41% with a reasonable distribution across contraceptive methods (pills, DMPA, BTL, and condoms in rank order).

The hospital did not calculate this basic postabortion contraceptive use rate, but the data were readily available. This use rate is somewhat parallel to the immediate postpartum female sterilization rate. The difference is that the postabortion FP use can appropriately be up to 80-85%, given that most incomplete or septic abortions are the result of a risky induced procedure outside the hospital in a dangerous attempt by the woman to end this pregnancy.

Women return to fertility with 2-3 weeks, making it essential to offer and provide a FP method before she leaves the facility. Some women will not be appropriate candidates for PAC FP, as they wanted to be pregnant.

PAC FP was generally not provided for women who had D & C procedures, because these were usually performed by private doctors who were not trained in PAC FP. Hospital staff was trained in MVA, as well as PAC FP. This represents a good opportunity to help private doctors also offer and provide PAC FP, after D & C, as well as MVA. There is no medical reason why such women should not receive a FP method.

(Hard copy of data attached in Manila office)

2. Davao Regional Hospital, Davao City

This large well equipped hospital has about 500 vaginal deliveries per month (estimated by the hospital director). Among the roughly 6,000 women with vaginal deliveries in 2002, 307 PP VSS procedures (BTLs) were performed, for a rate of 5% (see attached copy of BTL service statistics by year and month). This figure suggests the hospital is performing at the low end of the **modestly active service,** using the above PP VSS index.

The director noted that the hospital performed about 50% more BTLs, 42-50 per month, during the few months they had a dedicated PP VSS counselor from FriendlyCare on staff. **This temporary increase suggests that performance could be substantially enhanced with relatively modest measures, particularly around counseling.**

One operating room was dedicated to PP VSS, among the 8 ORs in the hospital. Another area was devoted to PAC, using MVA equipment for evacuating the uterus. We were not able to obtain PAC FP use data. The staff was very pleased with MVA equipment--general anesthesia was not required, so the women could return home the same day or with only one over-night stay.

The hospital staff seemed willing and able to provide PP VSS and PAC FP methods. They also performed itinerant female VSS in the area, along with other itinerant surgical procedures.

One drawback at this hospital is that spinal anesthesia has been used as a routine for PP minilap (ML) procedures. This is not an ideal technique, in that the risks and costs are increased, in comparison with ML under local with light sedation, and surgeons do not learn to operate using local. The prominence of anesthesiologists in policy decision-making at the hospital appears to be a partial explanation for this anomaly.

We presented the international consensus position, on behalf of LEAD, that spinal anesthesia would not be acceptable as a routine, if LEAD supports PP VSS procedures at this hospital in the future.

We also learned from the staff that they are capable of performing ML under local, as this is the routine for itinerant services. In fact, they perform the VSS cases first, since these women can go home the same day. Other itinerant surgical procedures under general anesthesia require patients to stay over night.

3. Interpretation of postpartum VSS and postabortion services at two hospitals

- The experience at these two hospitals supports the thesis that PP VSS can readily be part of hospital based maternity care. These two may be leading examples of active services in relation to other institutions.

- Itinerant interval female VSS can be a good service, and is already embraced by these institutions. Interval VSS is an important addition, so that it is a

ready option for the woman who does not choose or who is not a good candidate for a PP VSS procedure.

- Postabortion care can provide a high level of immediate PAC contraceptive use which is needed for almost all women who come to the hospital as a result of complications related to non-legal and potentially dangerous procedures. Immediate PAC contraception is a key intervention to prevent the need for abortion.

- PP VSS services can be increased with modest additional inputs for VSS, such as counseling. PAC contraceptive services should be offered to women having D & C uterine evacuation as well as MVA procedures. Continue to offer MVA equipment will help hospitals and staff improve services with lower cost.